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ABSTRACT

This paper describes an ongoing effort by an interdisciplinary team from a large urban university to extend and improve the mental health services in a 23-county rural area. The model is presented as the collaboration of professionals from different geographic and working environments with different professional expectations and goals. Aspects of the process of acculturation which occurs when urban-based mental health professionals undertake a commitment to provide services in rural areas are considered. Characteristics of the urban and rural settings are illustrated as influences on the provision and utilization of services. Also included are discussions of programmatic, theoretical, practical, and technical issues involved in developing and maintaining effective contacts with rural agencies. Demographics of the rural area are presented, with an emphasis on the lack of health care facilities and human services, and characteristics of the rural mental health system are detailed, including the lack of adequate facilities and trained personnel. A model for the provision of mental health consultation, education, and program development is outlined in terms of service dimensions, i.e., educational-clinical consultation, programmatic consultation, and training, research, and self-evaluation. (NRB)

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Academia goes to Appalachia: a model for urban-rural interface

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Introduction

In an article published in 1977, Johnson discusses the challenge of "how to live in two worlds without confusing them or ourselves," focusing on the contrasts between two different social or cultural contexts. Other authors have considered the theoretical and the practical problems involved in attempting to bridge the two worlds of urban and rural mental health systems, emphasizing the obstacles to understanding one orientation from the perspective of the other. (Riggs and Kugel, 1976; Berry and Davis, 1978; Jeffrey and Reeve, 1978). With the recent proliferation of studies and reports on rural health and mental health services, it is relevant to examine the process of "acculturation" which occurs when mental health professionals from an urban university undertake a commitment to provide services to a rural area. This paper will describe an ongoing effort by an interdisciplinary team to extend and improve the mental health services in the 23-county region of Western Pennsylvania. It will consider some of the implications of working in these two worlds, urban and rural, or more specifically, the urban university and the rural mental health system.

Mental health consultation has been defined as "the process of interaction between two professional persons...involving the management or treatment of clients or the planning or implementation of programs." (Caplan, 1963). Caplan's now-classic formulations of administrative and case consultations and client -, consultee -, and program-centered consultations have provided a useful framework for consultative activities during the past decade (Caplan, 1970). Recently, this "Caplan model" has been expanded and elaborated to reflect the demands of new legislation, the development of new programs and the corresponding multiplicity of consultative modalities (Hirschowitz, 1977;

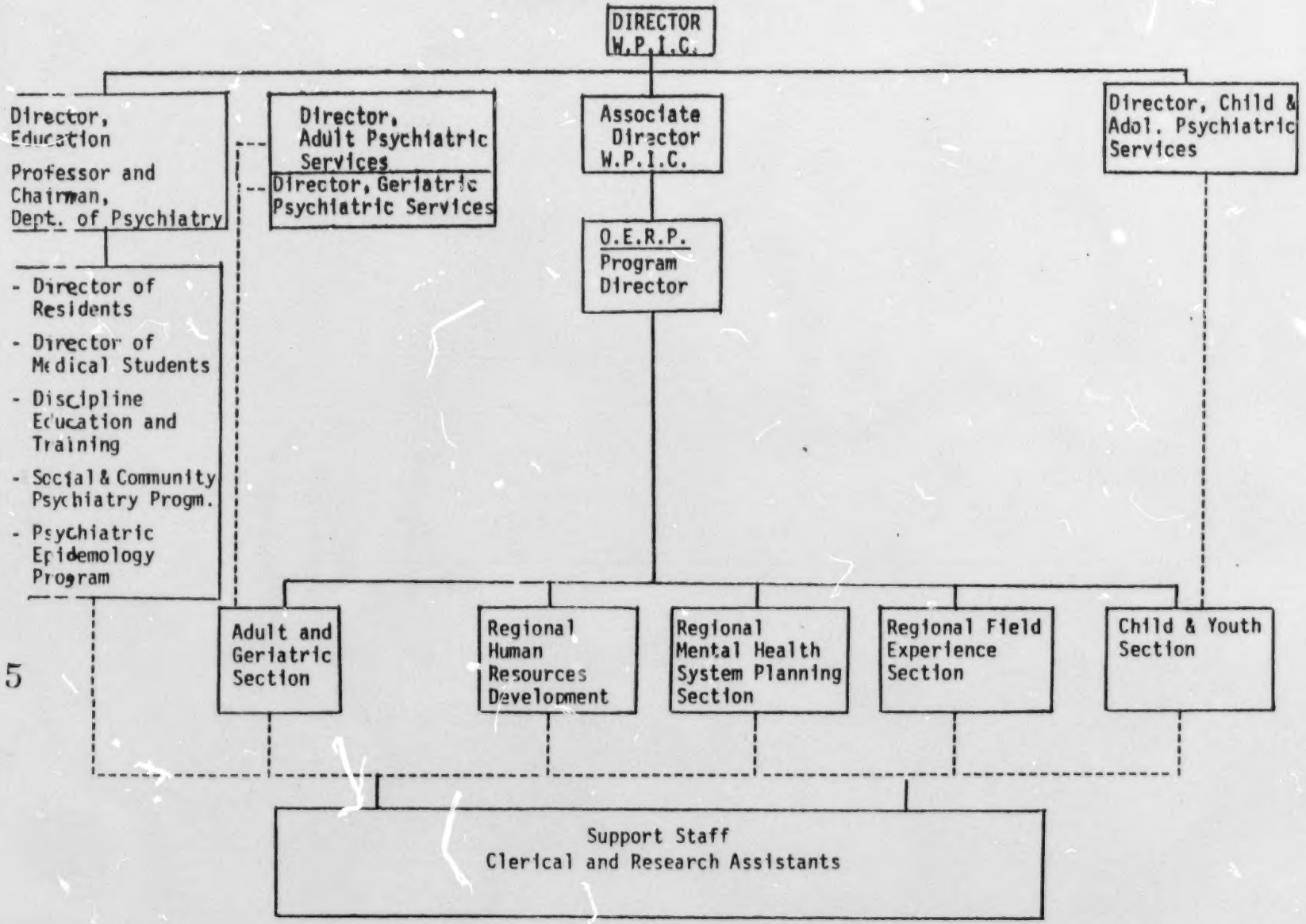
Kurpius, 1978; Berlin, 1979). The model described in this paper is characterized by the collaboration of professionals from different geographic settings and working environments who may also have differing professional expectations and goals. In developing the model, the implications of these differences have required continuous clarification and reassessment.

The urban university setting

The Office of Education and Regional Programming (OERP) was established in 1974 as an administrative and program unit in the Department of Psychiatry, University of Pittsburgh. It is located in the same building which houses the Western Psychiatric Institute and Clinic (WPIC) with its various inpatient and outpatient facilities, community mental health center and research programs. As the only medical school and psychiatric teaching center in Western Pennsylvania, this facility occupies a significant role in the provision of health care services to Pittsburgh and to the predominantly rural areas that surround it. The primary purpose of the OERP is to exentd the resources of the Department of Psychiatry and the WPIC to the entire Western Region and to support the efforts of the institutional and community-based mental health programs in this region to better serve the needs of the communities. In order to carry out this purpose, the OERP employs a multidisciplinary staff of 10 mental health professionals and utilizes the contributed services of 130 members of the faculty of the Department of Psychiatry. The organization of this Office and its functional relationship with the various units and programs in the Institute (see Table 1) make it possible to provide the wide range of clinical and consultative services which are described below.

TABLE 1

Organizational Structure
Office of Education and Regional Programming
Western Psychiatric Institute & Clinic
University of Pittsburgh


DIRECTOR W.P.I.C.
Director, Education
Professor and Chairman, Dept. of Psychiatry
- Director of Residents
- Director of Medical Students
- Discipline Education and Training
- Social & Community Psychiatry Progm.
- Psychiatric Epidemology Program
Director, Adult Psychiatric Services
Director, Geriatric Psychiatric Services
Associate Director W.P.I.C.
O.E.R.P. Program Director
Director, Child & Adol. Psychiatric Services
Adult and Geriatric Section
Regional Human Resources Development
Regional Mental Health System Planning Section
Regional Field Experience Section
Child & Youth Section
Support Staff
Clerical and Research Assistants

The Western Region

Western Pennsylvania consists of 23 counties bounded by West Virginia, Ohio, and New York and occupying 17,633 square miles, an area which is equivalent ot the size of Massachusetts and New Hampshire together. Eighteen of the 23 counties are predominatly rural, that is, more than 50% of the population live in communities with fewer than 2,500 inhabitants. In 14 counties there are fewer than 100 people per square mile. The region is part of the vast Appalachian Plateau and is characterized topographically by sloping valleys and heavily forested hillsides. In several counties, more than 90% of the land is forested. The population in the region varies, from the urban area around Pittsburgh with 2,200 people per square mile to the sparsely populated counties in the north, with fewer than 30 people per square mile. Of the total of 3,840,000 inhabitants, 6.3% are non-white. Only two cities have a population of more than 50,000 people.

Similar to other non-urban areas in the country, the rural counties of Western Pennsylvania are significantly lacking in health care facilities and other human services. Compared to national and state averages, every rural county in Western Pennsylvania is deprived of an adequate number of physicians and hospital beds. Inpatient psychiatric facilities are widely scattered and poorly staffed. Outpatient treatment is provided mainly by family physicians and community mental health clinics.

In addition to the shortage of human services, the inhabitants of this region are burdened with a high incidence of poverty and deprived living conditions. An analysis of social indicators confirms that these counties have a much lower median family income than the nation as a whole or the Commonwealth of Pennsylvania. Of the 1,265,000 children in the region, 25% live in overcrowded housing and almost 6% live in dwellings with sub-standard facilities (Madden, Stokes and Grossman, 1975). Table 2 documents some of

TABLE 2

DEMOGRAPHIC CHARACTERISTICS OF THE WESTERN REGION OF PENNSYLVANIA

(Based on the 1970 Census)

I. Population	Pa.	Western Region
A) Total population	11,794,000	3,839,000
B) Number of counties	67	23
C) % children	32.6	33.0
D) % adults	56.6	56.2
E) % elderly	10.8	10.8
F) % rural	28.5	60.4
II. Poverty		
A) Total population in poverty	10.6	12.8
B) % families in poverty	7.9	10.1
III. Housing		
A) % persons in overcrowded housing	11.8	13.7
B) % housing units without standard facilities	5.0	7.6
IV. Populations of High Potential Need		
A) % teenagers (14-17) not in school	5.9	7.1
B) % working mothers of children under 18	36.3	32.5
C) % working mothers of children under 6	24.8	22.3
D) % one-person households aged (65+)	8.6	8.8
E) % aged persons in poverty	24.4	30.2
F) % large households with low income	20.1	25.0
G) % female-headed families with children in poverty	4.3	3.9
H) % non-institutionalized population 16-64 disabled	10.5	10.6
I) % non-institutionalized population disabled & unable to work	4.2	4.6
J) % children under 18 in poverty	10.9	12.2

AVAILABILITY OF SERVICES FOR THE WESTERN REGION OF PENNSYLVANIA

(1978)

	Pa.	Western Region*
A) Number of physicians/1,000 population	1.4	0.7
B) Average number of psychiatrists/county	14.8	2.6
C) Average number of child psychiatrists/county	2.1	0.1
D) Average number of family practice physicians/county	18.0	8.0
E) Average number of pediatricians/county	12.6	3.1
F) Number of general hospital beds/1,000 population	4.8	4.4
G) Number of specialty (includes psychiatric) hospital beds/1,000 population	2.0	1.4

*excluding Allegheny County

the demographic characteristics and social indicators that influence the provision and utilization of mental health services in this region.

Mental health services are provided to the inhabitants of the 23 Western Region counties by 16 Mental Health/Mental Retardation programs which are responsible for the over-all operations of more than 30 community mental health centers and satellites and 24 Base Service Units or local administrative units. The mental health network also includes other agencies and programs which are needed to fulfill the mandates specified by legislation and regulations. These include Children and Youth Services, special programs for developmentally delayed children and adults, Day Care facilities and Drug and Alcohol programs. In addition to these community services, there are five state hospitals in the region, including one children's and one adolescent unit.

Peripherally-related to the mental health network are those facilities which belong to other systems but also provide some type of mental health service. There include juvenile detention centers, special education units and pre-school programs. Each county maintains a core of basic services, but the constellation of individual systems differs from one county to another, depending on local needs, resources, and political support.

Characteristics of a rural mental health system

Generalizations about rural life and rural communities are likely to be oversimplified and stereotypic. However, there are certain distinctive trends and conditions that seem to characterize the working climate of mental health systems in rural areas. The lack of adequate facilities and trained personnel has been amply documented by our staff (Benswanger, et. al. 1980) as well as by other authors (Hollister, 1973; Segal, 1973) the sophisticated diagnostic and treatment facilities and other back-up resources that

urban consultants take for granted are beyond the geographic and professional reach of most rural agencies. In most rural counties, there is also a scarcity of information resources and volunteer-staffed agencies. Because mental health services are a relatively recent addition to the human service network in many rural communities, they tend to be viewed with suspicion and mistrust by local residents. "You have to be crazy to go there" is a familiar expression of rejection of Community Mental Health Center services.

Rural Community Mental Health Center (CMHC) personnel are likely to have only limited training in any given area of specialty, but they often have considerable experience in the community. In some agencies, first-hand knowledge about the inhabitants and the rural environment seems to obscure or compensate for a lack of theoretical knowledge and clinical skills. Therapists, counselors and nurses in rural communities frequently are socially-related to their patients and clients and acquainted with family members as well as with family secrets. The problems engendered by such "closeness" cannot be resolved by traditional interpretations of transference and counter transference. They must be perceived and understood as a integral part of the working relationship.

The staffs of many CMHC's lack cohesion. The proportion of full-time staff members is low and key personnel (i.e. medical or psychiatric consultants) may rarely or never attend staff meetings. The psychiatric consultant is often viewed by the staff as a medication prescriber, and his or her valuable potential for staff training and supervision is not realized. In some agencies there is frequent turnover of personnel, especially among the better-trained staff members. One has the impression that the professionals with the most advanced degrees work the fewest hours and remain for the briefest period.

Staff members in a rural agency may be called upon to assume multiple roles. For example, in some rural communities, public health nurses serve

the functions of child protective workers, educators, and family counselors in addition to their usual nursing duties.

Agencies that are indirectly (and sometimes directly) related to the mental health system often must employ staff who have little or no mental health orientation and who represent diverse levels of training and administrative expertise. The wide range of capabilities is especially noticeable in multi-agency consultations, where the more advanced skills and sophisticated orientation of one agency may contrast vividly with the limitations of others. In such situations, a common language and an appropriate level of collaboration are difficult to achieve.

Additional problems must be recognized and confronted in the building-up of a collaborative relationship between professionals from different settings and orientations. Just as the urban professional might be tempted to attribute the rural professional's "faults" to the deprived aspects of the rural setting, the urban consultant's faults and limitations are often attributed to his foreign "urban" identity. The consultant's use of technical language, his detailed interpretations or insufficient direction are seen as related to his lack of knowledge and understanding of the rural working climate, rather than as attributes of an individual consultant.

The stereotypic image of a close-knit rural community with effective communication and smooth coordination of human services is not an accurate representation. The limited resources in rural areas seem to stimulate a great deal of "turf" conflicts, with similar agencies competing for clients and funds. Staff members at a particular level (i.e. case workers or psychologists) may not be familiar with the services provided by their colleagues in a parallel facility. The director of a special education unit may have never developed a working relationship with the director of a mental health clinic in the same

small town. The gaps in communication and the resistences to collaboration must be identified and confronted at each level of the rural network.

In addition to the conditions that characterize the working climate in rural areas, there are the day-to-day practical aspects of working "there" rather than "here" in the home office. The complicated logistics involved in arranging schedules, providing for the upkeep and availability of cars, learning the most direct routes, initiating and maintaining phone contacts with a multiplicity of agency personnel, these activities require an enormus investment of energy and planning and are greatly facilitated by our support staff and clerical assistants.

Some of the positive aspects of working in rural areas have been observed by our staff and described by others (Cordes, 1978) i.e., the respect granted to the "healer" or service provider, the more personalized, responsive care, the sense of closeness to the community, the visible presence of natural support systems, the greater acceptance of deviant behaviors. These assets as well as the negative factors and deprivations influence the process of "acculturation" which our work requires and demand a continuous reassessment of our own approach and orientation.

An evolving model for consultative services

During the past three years, the services provided to the Western Region by the OERP have been gradually expanded and refined. A model is emerging for the provision of mental health consultation, education and program development. Taking into consideration the characteristics of the rural communities and mental health systems, the capabilities of our staff, the availability of professional resources, and the problems involved in developing effective collaborative relationships, the following dimensions of services have evolved:

A. Educational - clinical consultation

Definition: The enrichment and improvement of general knowledge and specific skills in order to upgrade the services provided by staff at state hospitals, community mental health centers and other agencies related to the mental health system.

Examples:

I. Professional Education

a. A series of medical lectures for the staffs of state hospitals designed to improve the medical care of patients.

b. A series of seminars on child development for the staffs of community mental health centers.

c. Workshops on staff burn-out and obesity for staffs of the mental health system network.

d. Workshops and seminars for community agencies on various aspects of mental retardation, social skills training, behavioral management, and crisis intervention.

e. Lectures at state hospitals on psychiatric issues such as the treatment of depression, the chronic schizophrenic in the community, therapeutic activities for geriatric patients.

f. Workshops and conferences on medical audits for state hospital personnel.

g. A series of workshops on therapeutic skills, for para-professionals and new professionals at state hospitals.

II. Clinical consultation

a. Weekly case-centered consultations, with alternating focus on the diagnosis and the treatment of children with behavior disorders, for the staff of a community mental health center.

b. Problem-centered case consultations, focused on such issues as child abuse, foster home placement and multi-problem families, for Children and Youth Service Case workers.

c. A series of lectures on cognitive disorders, treatment modalities, and case management issues, for state hospital staff.

d. Workshops on play therapy for staffs of community mental health centers, Day Care and Head Start programs.

B. Programmatic consultation

Definition: The extension and refinement of information and techniques, and the development of new policies which will lead to more effective planning, implementation and evaluation of mental health programs.

Examples:

I. Program evaluation and planning

a. Study and evaluation of county-wide services for children, youth and families.

b. Study and evaluation of the interface between the mental health components of a Special Education Unit in a three-county rural area and the mental health system which serves the same area.

c. Analysis of trends and patterns in the entries to and exits from five state hospitals during an eight year period.

d. Investigation of the causes of attrition in the client population of a community mental health center and implementation of recommended remedies.

e. Study and evaluation of specific components of a mental health program, such as Outpatient Services, Aftercare Services and Intake and Referral Procedures.

II. Administrative consultation

a. A series of conferences and workshops for all Mental Health Program administrators and clinic directors in the region, to review current MH/MR mandates, consider new procedures for data collection and needs assessment, and present issues related to financial management and organizational development.

b. Consultative and technical assistance in the formulation of need assessments, management information systems, and cost effective methods.

c. Consultations to state hospital administrators in the development of a discharge plan for patients.

d. Consultations to state hospitals and community mental health programs on the identification of staff training needs.

e. Technical assistance in the preparation of specific grant proposals, i.e. Community Mental Health Center operations grants; proposal for an adolescent health center.

III. Community and Program Development

a. Consultations on the development and coordination of inter-agency and auxilliary services for the chronically-mentally-ill in one rural catchment area.

b. Mobilization and coordination of mental health services for children in a three-county area.

c. Consultation and technical assistance in the planning of housing facilities for de-institutionalized chronically-ill.

d. Formation of Executive Child Advocacy Committees in several counties, to plan, develop and coordinate services at the administrative level.

e. Formation, consultation and evaluation of SCAN, inter-agency case-conferences on child abuse and neglect.

C. Training, research and self-evaluation

In addition to the consultative and educational services described above, a variety of professional activities serve to support, extend and improve the model. These include the following examples:

I. Training

a. A group of post-baccalaureate students were trained as child development specialists and supervised in field experiences in four rural communities for a period of three years.

b. Child psychiatry residents in their fifth year of training are being provided with weekly field experience and supervision for a six-month period in five rural communities.

II. Research

a. A study of infant death in a rural community (Benswanger, et.al., 1980).

b. A study of child abuse, focusing on the reporting practices of medical and dental specialists in urban and rural areas (in progress)

c. A study of the relationships among human service agencies in selected rural communities, utilizing the techniques of social network analysis (in progress).

d. A report on the status of children and youth in Western Pennsylvania in regard to health, mental health, education and human services, for the Western Pennsylvania Subcommittee, International Year of the Child.

e. A study of services to prevent and reduce the incidence of child abuse in three rural communities. (In progress).

III. Self-evaluation

a. Evaluation by Community Mental Health Center staff of weekly consultations and educational seminars provided by OERP.

b. Evaluation by child development specialists of the curriculum, brief placements, field experience and supervision which constituted their training.

c. Ongoing formulation of a standardized assessment methodology for consultative/evaluative studies.

Conclusion

This paper represents an effort to describe a model of mental health consultation which has been developed by a staff of professionals from an urban university for a network of rural agencies in a 23-county area. It attempts to illustrate the characteristics of the urban and rural settings, as they influence the provision and utilization of services. It also includes a discussion of some of the practical aspects of developing such a model. Through a continuous process of clarification and reassessment of our approach, orientation and methods, it gradually becomes possible to "live in two worlds without confusing them or ourselves."

The rural setting has proved to be a persistent challenge and an invaluable resource in the effort to develop a viable model of mental health consultation.

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